CHILDEN DIE:

HOW?
WHY?
WHAT CAN WE DO?

Alabama Department of Child Abuse and Neglect Prevention
Grantee Training

The Alabama Child Death Review System (ACDRS)

Aretha D. Bracy
Director

The ACDRS Mission

To understand how and why children die in Alabama in order to prevent future child deaths.

Focus on Prevention

- The primary purpose of ACDRS…
  - … is ***prevention***.
  - … is **NOT** prosecution.
  - … is **NOT** oversight.
  - … is **NOT** criticism.

CDR History Nationwide

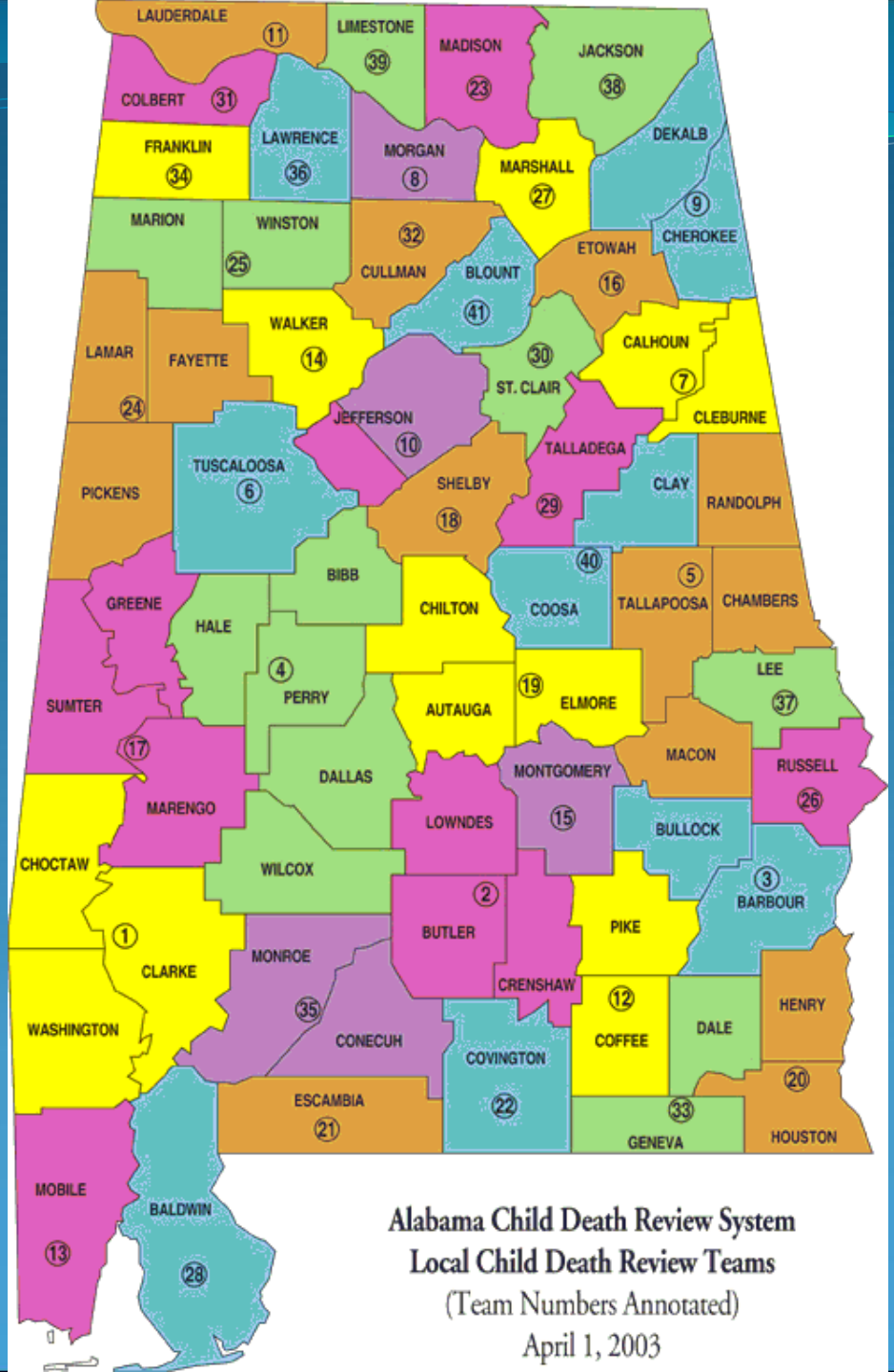
- 1978 – Local teams begin in Los Angeles, Oregon, and North Carolina to better identify child abuse
- 1980s – Teams expand to other states
- 1990s – Improve reviews through several initiatives
- 2000s – Integration of CDR and FIMR
  - National Reporting System launched
  - Federal Legislation introduced to support CDR
- Today - 50 State CDR Programs

ACDRS State Law

- Signed on September 11, 1997
- Created ACDRS & State & Local Child Death Review (CDR) Teams
- Tasks:
  - Review
  - Educate
  - Prevent

Structure

- State office
  - Alabama Department of Public Health
  - Three full-time staff
- Local Child Death Review Teams
  - 42 multidisciplinary teams of professionals statewide
  - Meet at least annually/based upon caseload
- State Child Death Review Team
  - 28-member multidisciplinary team of professionals
  - Meets quarterly


LAUDERDALE
11
LIMESTONE
39
MADISON
23
JACKSON
38
COLBERT
31
LAWRENCE
36
MORGAN
8
MARSHALL
27
DEKALB
9
FRANKLIN
34
MARION
WINSTON
25
32
CULLMAN
BLOUNT
41
ETOWAH
16
CHEROKEE
WALKER
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LAMAR
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FAYETTE
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ST. CLAIR
CALHOUN
7
CLEBURNE
JEFFERSON
10
TALLADEGA
29
TUSCALOOSA
6
PICKENS
SHELBY
18
CLAY
RANDOLPH
BIBB
40
CHILTON
COOSA
5
TALLAPOOSA
CHAMBERS
GREENE
HALE
4
PERRY
AUTAUGA
19
ELMORE
LEE
37
SUMTER
17
DALLAS
MONTGOMERY
15
MACON
RUSSELL
26
MARENGO
LOWNDES
BULLOCK
CHOCTAW
WILCOX
2
BUTLER
3
BARBOUR
1
CLARKE
MONROE
PIKE
CRENSHAW
12
HENRY
WASHINGTON
35
CONECUH
COVINGTON
COFFEE
DALE
20
ESCAMBIA
22
33
GENEVA
HOUSTON
MOBILE
13
BALDWIN
28
Alabama Child Death Review System
Local Child Death Review Teams
(Team Numbers Annotated)
April 1, 2003

Operation

- Death certificates
  - All child death certificates reviewed at state level
  - Deaths meeting criteria assigned to appropriate local team
- Local reviews
  - Deaths meeting criteria reviewed in-depth by local teams
  - Completed case reports submitted back to state office

Official Manners of Death

- Natural Causes
- Accidental
- Suicide
- Homicide
- Undetermined

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12

ALABAMA CERTIFICATE OF DEATH

State File Number 101 2013-

1. DECEASED LEGAL NAME				2. DATE AND TIME OF DEATH
3. ALIAS NAME(IF ANY) None Given				4. DATE AND TIME PRONOUNCED DEAD
5. COUNTY OF DEATH	6. CITY, TOWN OR LOCATION OF DEATH AND ZIP		7. PLACE OF DEATH	
8. HISPANIC ORIGIN No	9. RACE White		10. SEX Male	11. SERVED IN ARMED FORCES No
12. AGE	UNDER 1 YEAR: MONTHS / DAYS	UNDER 1 DAY: HRS / MINS	13. DATE OF BIRTH	14. STATE OF BIRTH Alabama / 15. SOCIAL SECURITY NUMBER
16. MARITAL STATUS Never Married	17. SURVIVING SPOUSE			18. RESIDENCE STATE Alabama
19. RESIDENCE COUNTY	20. CITY, TOWN OR LOCATION AND ZIP		21. STREET ADDRESS	
22. INFORMANT NAME, RELATIONSHIP AND ADDRESS				23. OCCUPATION student / 24. BUSINESS OR INDUSTRY education
25. FATHER'S NAME			26. MOTHER'S MAIDEN NAME	
27. DISPOSITION OF BODY Burial	28. DATE OF DISPOSITION	29. CEMETERY OR CREMATORY		30. LOCATION
31. FUNERAL HOME NAME AND ADDRESS				32. LICENSE NUMBER
33. FUNERAL DIRECTOR			34. LICENSE NUMBER	35. DATE SIGNED

36. **MEDICAL CERTIFICATION:** ___ CERTIFYING PHYSICIAN ___ MEDICAL EXAMINER X CORONER

37. NAME	38. LICENSE NUMBER	39. DATE SIGNED
40. ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH		
41. REGISTRAR Catherine Molchan Donald		42. DATE FILED

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CAUSE OF DEATH

43. PART I. DISEASES, INJURIES OR COMPLICATIONS THAT CAUSED DEATH — INTERVAL

IMMEDIATE CAUSE — A. Multiple Blunt Force injuries — DUE TO (OR AS A CONSEQUENCE OF): — Minutes

UNDERLYING CAUSE — B. DUE TO (OR AS A CONSEQUENCE OF):

C. DUE TO (OR AS A CONSEQUENCE OF):

D.

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44. PART II. OTHER SIGNIFICANT CONDITONS CONTRIBUTING TO DEATH

45. MANNER OF DEATH	46. PREGNANCY IN LAST 42 DAYS	47. AUTOPSY	48. FINDINGS CONSIDERED	49. DATE AND TIME OF INJURY
Accident	No	No		

50. HOW INJURY OCCURRED: Passenger in motor vehicle which left roadway and hit a tree

51. INJURY AT WORK	52. PLACE OF INJURY	53. LOCATION OF INJURY
No	County Roadway	

ADPH HS E2/REV 07-10

RECEIVED
APR 2 4 2013
BY ACDRS

ACDRS REVIEW Veh

36.

MEDICAL CERTIFICATION: ___ CERTIFYING PHYSICIAN ___ MEDICAL EXAMINER _X_ CORONER

37. NAME	38. LICENSE NUMBER	39. DATE SIGNED

40. ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH

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Catherine Molchan Donald	

CAUSE OF DEATH

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ADPH HS E2/REV 07-1

Operation

- Local reviews
  - Qualifying deaths are reviewed in-depth by local teams
    - District Attorney or designee
    - Local Coroner and/or Medical Examiner
    - Law Enforcement (local, county, & state)
    - Fire and/or EMS
    - Local Healthcare Provider
    - State Government: ADPH, DHR, DMH
    - Local CAC representative
    - Probate or Family Court representative
    - Educators
    - Others (clergy)
- Completed case reports submitted back to state office

Operation

- Data collection & analysis
  - Completed case reports from local teams compiled into database
  - Database queried as needed for specific data & reports
  - Database analyzed annually for reporting purposes

CDR Case Reporting System

- Funded by MCHB / HRSA / HHS
- Most US states use the reporting system
- Comprehensive multipurpose collection tool
- Secure and confidential
- Web-based
- No special software required
- Programmers available at the National Center for ongoing assistance

NATIONAL CFRP

Center for Fatality Review & Prevention

Login to the CDR Case Reporting System

User name

Password

Log in

I Forgot My Password

Child Death Review (CDR) leads to a better understanding of how and why children die and catalyzes actions to prevent other deaths. The National Center for Fatality Review and Prevention, in collaboration with state CDR programs, developed and manages this web-based reporting system. Users of this system can enter CDR case review data so that their findings can be tabulated at the local, state and national level. Findings from these reviews guide program, service and policy efforts to keep children safe, healthy and alive.

If you are not currently a registered user, please contact info@childdeathreview.org for information on enrolling your state and local teams into the system.

Funding for the NCFRP is provided in large part by the Maternal and Child Health Bureau (Title V Social Security Act), Health Resources Services Administration, US Department of Health and Human Services.

For additional information and help with your login contact us:

NCFRP
1115 Massachusetts Avenue, NW
Washington, DC 20005
1-800-656-2434

Email:
info@childdeathreview.org

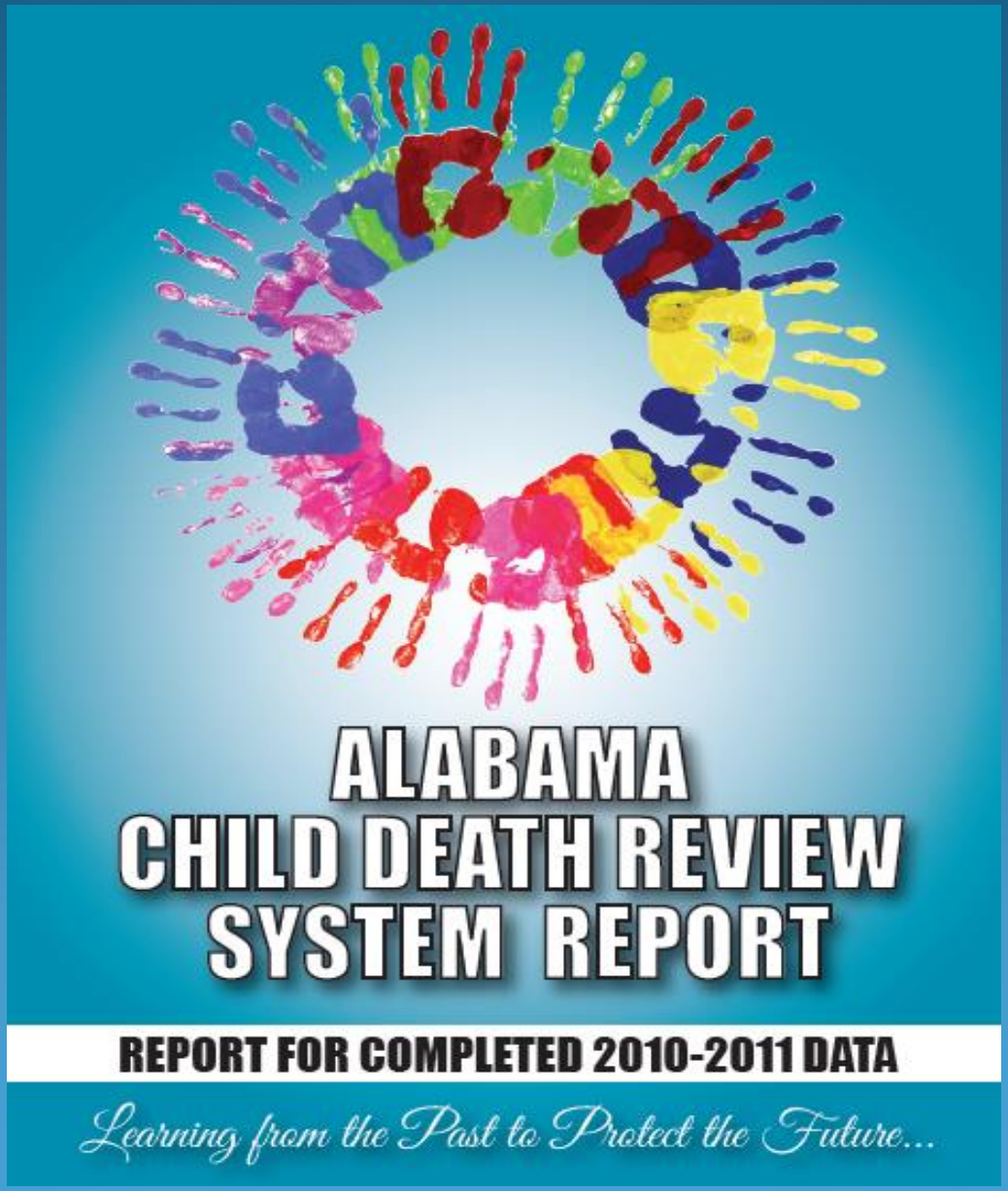
Web site:
www.childdeathreview.org

We are a National Resource Center Supporting Child Death Review in States and Communities

Saving Lives Together

Operation

- Reports & recommendations
  - Annual Report published with analysis of most recent available complete data
  - Recommendations made to the Governor, Legislators, and the general public based upon analyzed data


ALABAMA
CHILD DEATH REVIEW
SYSTEM REPORT
REPORT FOR COMPLETED 2010-2011 DATA
Learning from the Past to Protect the Future...

Alabama State Child Death Review Team

Formal Recommendations – Adopted November 13, 2015

Vehicular deaths are the leading category of preventable deaths to Alabama children less than eighteen years of age reviewed by the Alabama Child Death Review System and, in fact, account for between one-third and one-half of all such deaths in any given year.

The State Child Death Review Team recommends:

- Comprehensive statewide awareness and education campaigns related to teen driver safety and child passenger safety
- Enhancement of the current Graduated Driver's License (GDL) Law by increasing the limitations on late-hour driving by graduated licensees and reconsidering the current exemptions
- Enhancement of child passenger restraint laws in accordance with the latest AAP recommendations
- Promotion of the use of parent-teen driver contracts and log books
- Establishment of a minimum age to operate All-Terrain Vehicles (ATVs)
- Safety training requirements for ATV operators
- Prohibition of passengers from ATVs
- Prohibition of passengers from open truck beds on public roads

Infant sleep-related deaths are the second-leading category of preventable deaths to Alabama children less than eighteen years of age reviewed by the Alabama Child Death Review System and are by far the most likely cases to be misdiagnosed as to their manners and causes.

The State Child Death Review Team recommends:

- Expansion of statewide safe infant sleep awareness and education campaigns
- Adherence to the protocols developed by the Alabama Sudden Unexplained Infant Death Investigation (SUIDI) Team

Fatality prevention and injury prevention are closely related. Access to fatality data has proven essential to the accurate collection and analysis of fatality data required for effective fatality prevention efforts. At the same time, limited access to injury data in Alabama has been a significant barrier to injury prevention funding and efforts.

The State Child Death Review Team recommends:

- Securing access to comprehensive injury data in Alabama for the ADPH Injury Prevention Branch

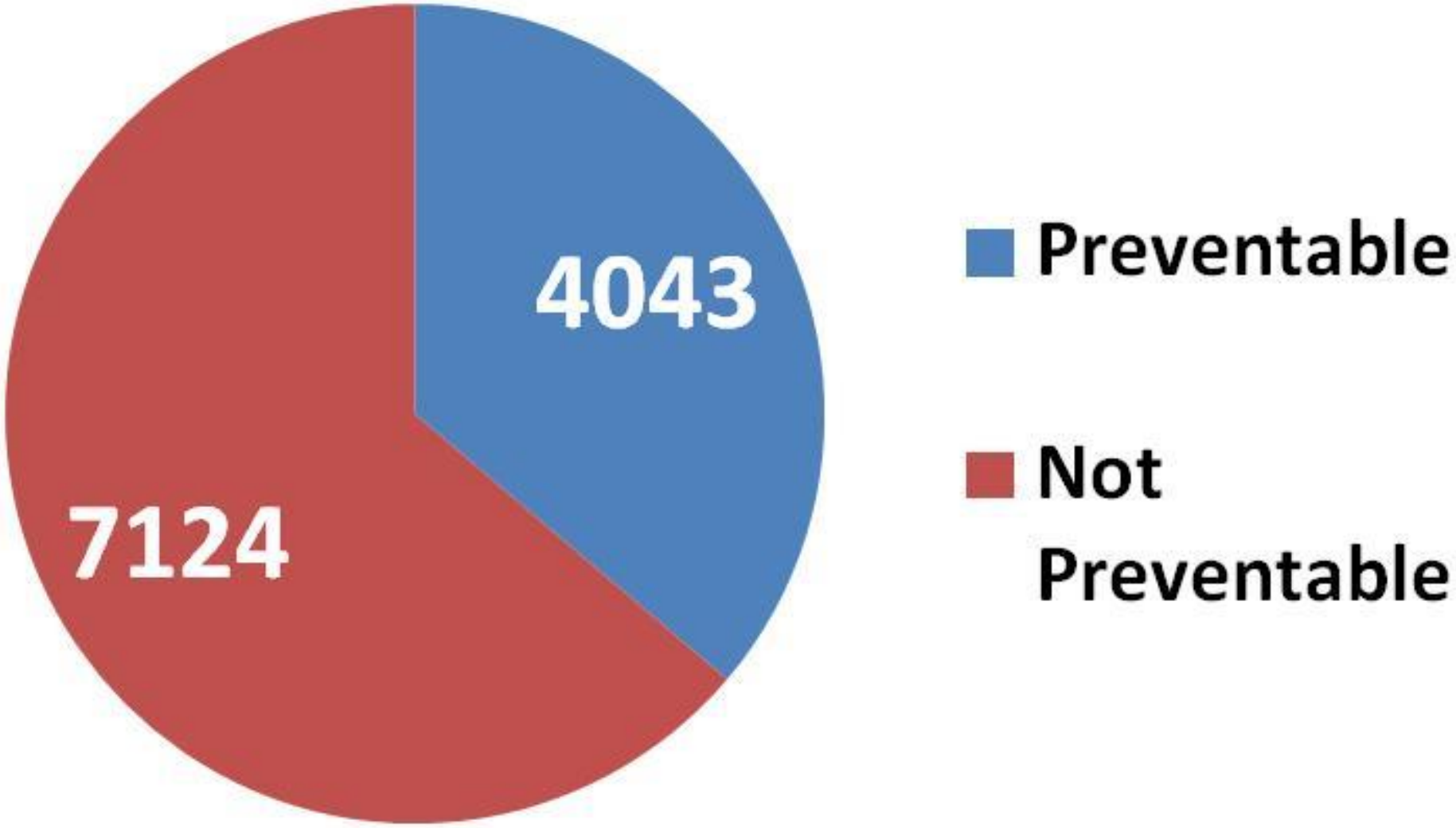
ACDRS Recommendations

- Based upon CDR findings
- May include:
  - Legislation
  - Policy & procedure
  - Education & awareness

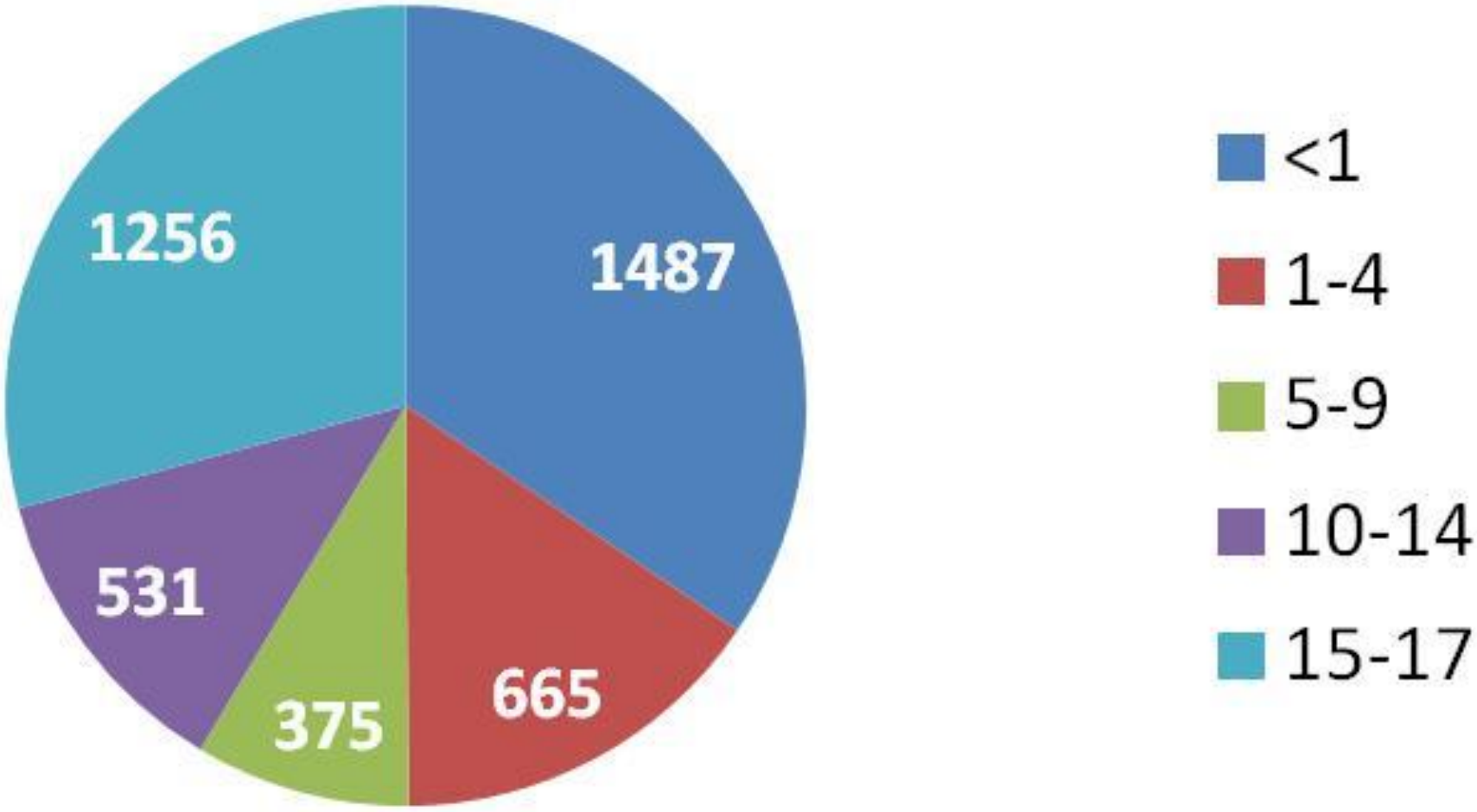
Recommendation Issues

- Improved child death investigations
- Child passenger safety
- Truck bed passengers
- ATV safety
- Infant safe sleep best practices
- Smoke & CO detectors
- Swimming area safety/regulations

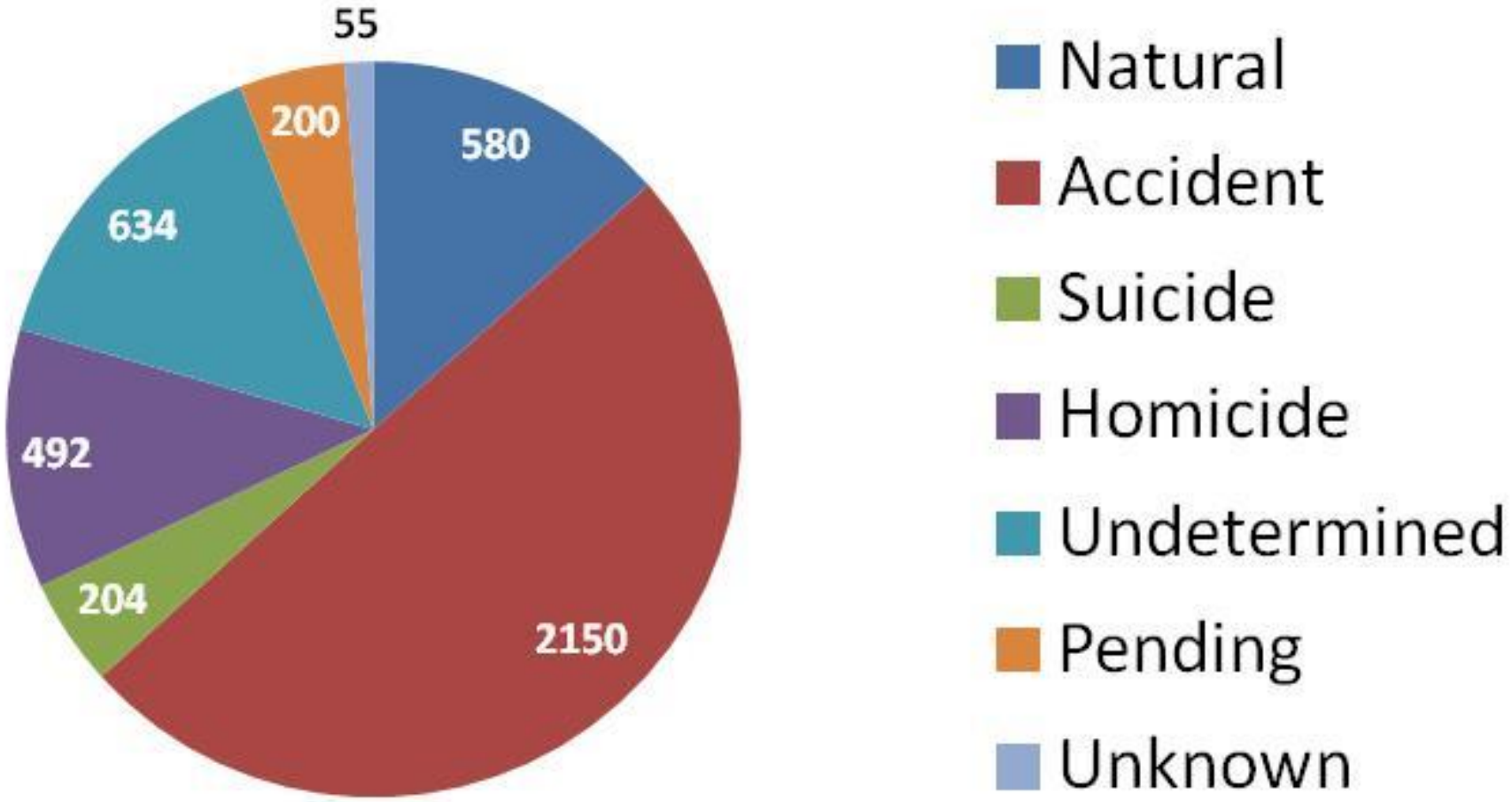
Child Deaths in AL from 2000 to 2013

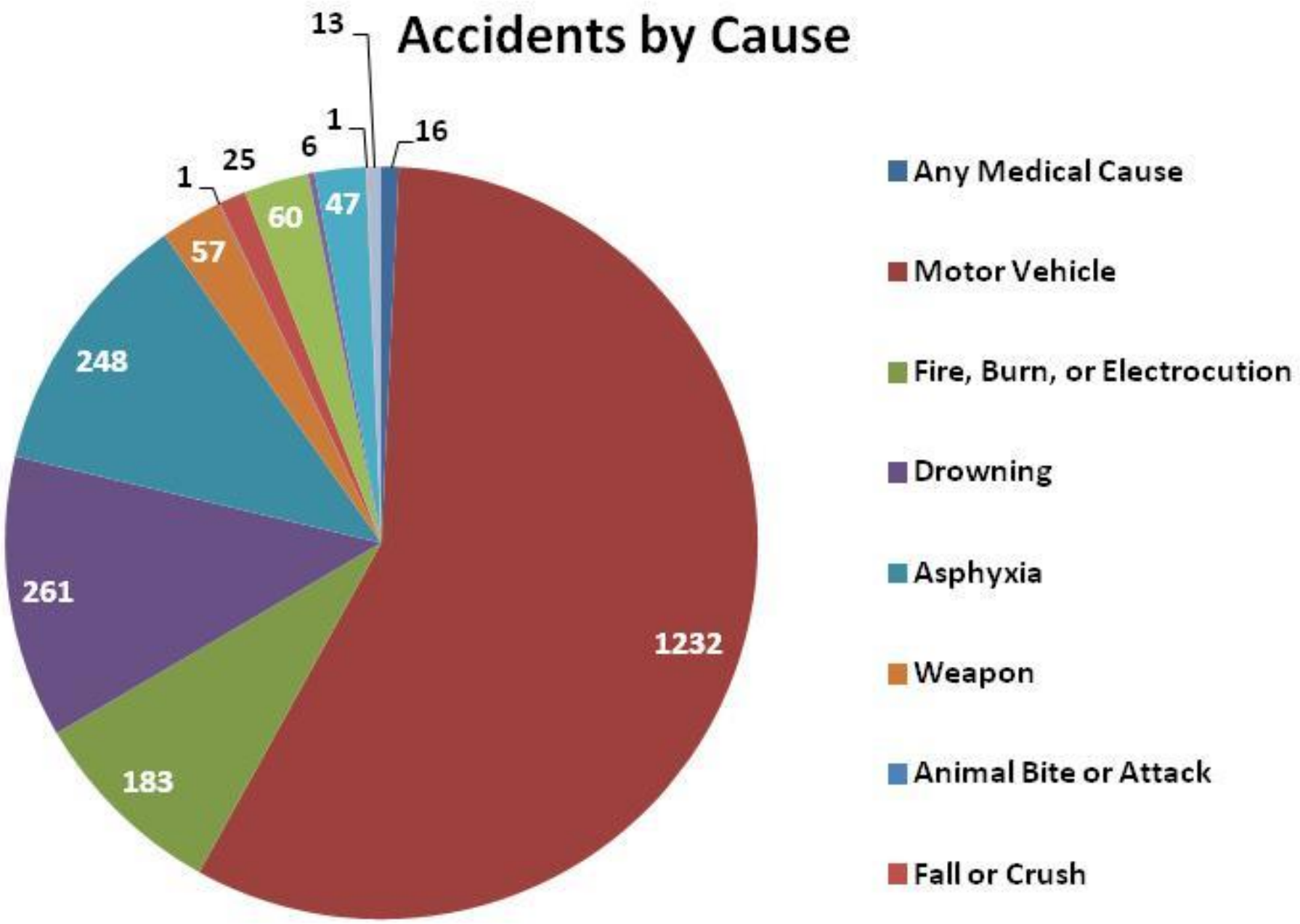


Preventable AL Child Deaths Reviewed by Age

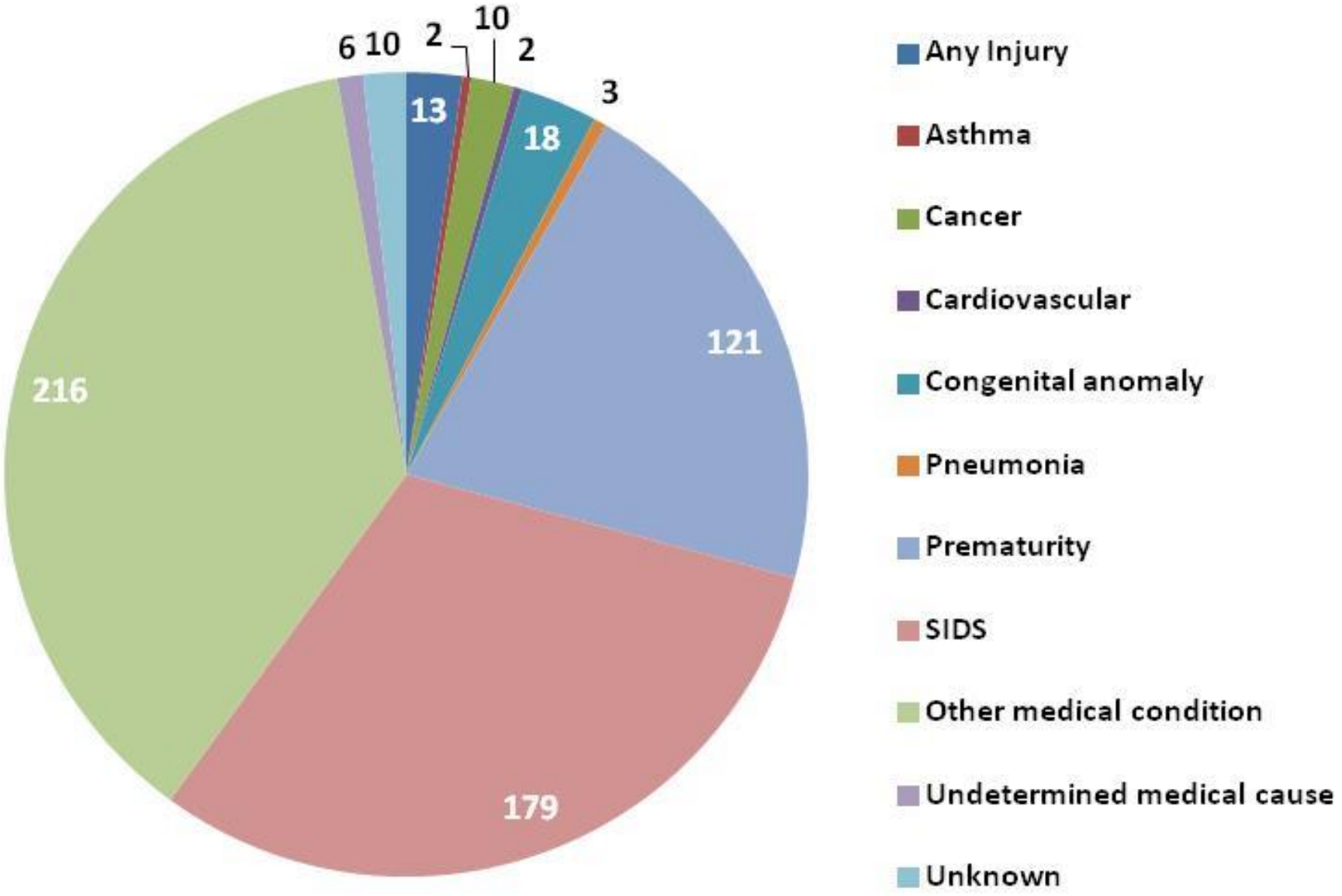


Preventable AL Child Deaths Reviewed by Manner




Accidents by Cause
13
1
16
6
25
1
60
47
57
248
261
1232
183
Any Medical Cause
Motor Vehicle
Fire, Burn, or Electrocution
Drowning
Asphyxia
Weapon
Animal Bite or Attack
Fall or Crush

Natural by Cause



Awareness, Education, and Prevention

- Awareness
  - Basic knowledge
- Education
  - Greater knowledge and detail
- Prevention
  - Behavior change

Child Vehicular Deaths

- Passenger-specific strategies
  - Restraint Laws and Education
  - Car Seat Distribution and Clinics
- Driver-specific strategies
  - Graduated Driver License Laws
  - Parent-Teen Driver Contracts
  - Narrowly-Focused Outreach

Infant Sleep Related Deaths Prevention Efforts

- Cribs For Kids
- CPSC Efforts (Recalls)
- “Safe To Sleep” Campaigns
- COIIN Efforts

Child Suicide and Homicide

- School-based programs
- Gatekeeper training
  - Adults
  - Peers
- Bullying interventions
- Means reduction
- Mental Health and SEC approaches

Child Drownings

- Everyone should learn life-saving skills
  - Swimming / floating
  - CPR
- Four-sided fencing
- Life-vests and flotation devices
- Strong supervision around any water

Child Fire-Related Deaths

- Working smoke detectors
- Family emergency / escape plans
- Safe cooking practices
- Safe home heat
- Fire extinguishers

Results We Hope To See

- More Scene Investigations
- Better Scene Investigations
- More Accurate Death Diagnoses
- More Accurate Trend Analysis
- Better Prevention Efforts
- Fewer Child Deaths

Questions?

Thank you!

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www.adph.org/cdr
334-206-2953